General Assembly

Raised Bill No. 370

February Session, 2016

LCO No. **2134**

____SB00370INS__033116___

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING HEALTH CARE PROVIDER LISTS AND AUTHORIZING PREGNANCY AS A QUALIFYING EVENT FOR SPECIAL ENROLLMENT PERIODS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-472f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

Each insurer, health care center, managed care organization or other entity that delivers, issues for delivery, renews, amends or continues an individual or a group health insurance policy or medical benefits plan, and each preferred provider network, as defined in section 38a-479aa, that contracts with a health care provider, as defined in section 38a-478, for the purposes of providing covered health care services to its enrollees, shall maintain (1) a network of such providers that is consistent with the National Committee for Quality Assurance's network adequacy requirements or URAC's provider network access and availability standards, and (2) an accurate and current list of in-network health care providers and facilities for each such policy, plan or network. Such list shall (A) include (i) the name of each health care

provider and the address and phone number of each office or practice where such provider provides health care services to patients, (ii) the name or names of any hospital at which each such provider enjoys privileges, (iii) any specialty and board certification of each such provider, (iv) any language besides English that each such provider speaks, and (v) the name, address and phone number of each facility, and (B) be in a machine readable format as described by the United States Department of Health and Human Services.

Sec. 2. Section 38a-567 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

Health insurance plans, associations of small employers and other insurance arrangements covering small employers and insurers and producers marketing such plans and arrangements shall be subject to the following provisions:

(1) (A) Any such plan or arrangement shall be offered on a guaranteed issue basis with respect to all eligible employees or dependents of such employees, at the option of the small employer, policyholder or contractholder, as the case may be.

(B) Any such plan or arrangement shall be renewable with respect to all eligible employees or dependents at the option of the small employer, policyholder or contractholder, as the case may be, except: (i) For nonpayment of the required premiums by the small employer, policyholder or contractholder; (ii) for fraud or misrepresentation of the small employer, policyholder or contractholder or, with respect to coverage of individual insured, the insureds or their representatives; (iii) for noncompliance with plan or arrangement provisions; (iv) when the number of insureds covered under the plan or arrangement is less than the number of insureds or percentage of insureds required by participation requirements under the plan or arrangement; or (v) when the small employer, policyholder or contractholder is no longer actively engaged in the business in which it was engaged on the

effective date of the plan or arrangement.

(C) Renewability of coverage may be effected by either continuing in effect a plan or arrangement covering a small employer or by substituting upon renewal for the prior plan or arrangement the plan or arrangement then offered by the carrier that most closely corresponds to the prior plan or arrangement and is available to other small employers. Such substitution shall only be made under conditions approved by the commissioner. A carrier may substitute a plan or arrangement as set forth in this subparagraph only if the carrier effects the same substitution upon renewal for all small employers previously covered under the particular plan or arrangement, unless otherwise approved by the commissioner. The substitute plan or arrangement shall be subject to the rating restrictions specified in this section on the same basis as if no substitution had occurred, except for an adjustment based on coverage differences.

(D) Any such plan or arrangement shall provide special enrollment periods (i) to all eligible employees or dependents as set forth in 45 CFR 147.104, as amended from time to time, **[**and**]** (ii) for coverage under such plan or arrangement ordered by a court for a spouse or minor child of an eligible employee where request for enrollment is made not later than thirty days after the issuance of such court order, and (iii) to all eligible pregnant employees at any time after the commencement of the pregnancy, as certified by a physician licensed under chapter 370 or an advanced practice registered nurse licensed under chapter 378, acting within the scope of such physician's or nurse's scope of practice. Coverage under subparagraph (D)(iii) of this subdivision shall be effective as of the first of the month in which the employee receives such certification.

(2) (A) As used in this subdivision, "grandfathered plan" has the same meaning as "grandfathered health plan" as provided in the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time.

(B) With respect to grandfathered plans issued to small employers, the premium rates charged or offered shall be established on the basis of a single pool of all grandfathered plans, adjusted to reflect one or more of the following classifications:

(i) Age, provided age brackets of less than five years shall not be utilized;

(ii) Gender;

(iii) Geographic area, provided an area smaller than a county shall not be utilized;

(iv) Industry, provided the rate factor associated with any industry classification shall not vary from the arithmetic average of the highest and lowest rate factors associated with all industry classifications by greater than fifteen per cent of such average, and provided further, the rate factors associated with any industry shall not be increased by more than five per cent per year;

(v) Group size, provided the highest rate factor associated with group size shall not vary from the lowest rate factor associated with group size by a ratio of greater than 1.25 to 1.0;

(vi) Administrative cost savings resulting from the administration of an association group plan or a plan written pursuant to section 5-259, provided the savings reflect a reduction to the small employer carrier's overall retention that is measurable and specifically realized on items such as marketing, billing or claims paying functions taken on directly by the plan administrator or association, except that such savings may not reflect a reduction realized on commissions;

(vii) Savings resulting from a reduction in the profit of a carrier that writes small business plans or arrangements for an association group plan or a plan written pursuant to section 5-259, provided any loss in overall revenue due to a reduction in profit is not shifted to other small employers; and

(viii) Family composition, provided the small employer carrier shall utilize only one or more of the following billing classifications: (I) Employee; (II) employee plus family; (III) employee and spouse; (IV) employee and child; (V) employee plus one dependent; and (VI) employee plus two or more dependents.

(C) (i) With respect to nongrandfathered plans issued to small employers, the premium rates charged or offered shall be established on the basis of a single pool of all nongrandfathered plans, adjusted to reflect one or more of the following classifications:

(I) Age, in accordance with a uniform age rating curve established by the commissioner;

(II) Geographic area, as defined by the commissioner.

(ii) Total premium rates for family coverage for nongrandfathered plans shall be determined by adding the premiums for each individual family member, except that with respect to family members under twenty-one years of age, the premiums for only the three oldest covered children shall be taken into account in determining the total premium rate for such family.

(iii) Premium rates for employees and dependents for nongrandfathered plans shall be calculated for each covered individual and premium rates for the small employer group shall be calculated by totaling the premiums attributable to each covered individual.

(iv) Premium rates for any given plan may vary by (I) actuarially justified differences in plan design, and (II) actuarially justified amounts to reflect the policy's provider network and administrative expense differences that can be reasonably allocated to such policy.

(3) No small employer carrier or producer shall, directly or indirectly, engage in the following activities:

(A) Encouraging or directing small employers to refrain from filing

an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer, except the provisions of this subparagraph shall not apply to information provided by a small employer carrier or producer to a small employer regarding the carrier's established geographic service area or a restricted network provision of a small employer carrier; or

(B) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(4) No small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation or geographic area of the small employer. A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a health care plan. No small employer carrier shall terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.

(5) No small employer carrier or producer shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(6) No small employer carrier or producer shall disclose (A) to a small employer the fact that any or all of the eligible employees of such small employer have been or will be reinsured with the pool, or (B) to any eligible employee or dependent the fact that he has been or will be reinsured with the pool.

(7) If a small employer carrier enters into a contract, agreement or other arrangement with another party to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the other party shall be subject to the provisions of this section.

(8) The commissioner may adopt regulations, in accordance with the provisions of chapter 54, setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers.

(9) Any violation of subdivisions (3) to (7), inclusive, of this section and of any regulations established under subdivision (8) of this section shall be an unfair and prohibited practice under sections 38a-815 to 38a-830, inclusive.

Sec. 3. Subsection (g) of section 38a-481 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(g) (1) As used in this subsection, "Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, and regulations adopted thereunder, and "grandfathered plan" has the same meaning as "grandfathered health plan" as provided in the Affordable Care Act.

(2) Each individual health insurance policy subject to the Affordable Care Act shall (A) be offered on a guaranteed issue basis with respect to all eligible individuals or dependents, and (B) provide special enrollment periods (i) to all eligible individuals or dependents as set forth in 45 CFR 147.104, as amended from time to time, and (ii) to all eligible pregnant individuals at any time after the commencement of the pregnancy, as certified by a physician licensed under chapter 370 or an advanced practice registered nurse licensed under chapter 378, acting within the scope of such physician's or nurse's scope of practice. Coverage under subparagraph (B)(ii) of this subdivision shall be

effective as of the first of the month in which the employee receives such certification.

(3) With respect to grandfathered plans of a policy under subdivision (2) of this subsection, the premium rates charged or offered shall be established on the basis of a single pool of all grandfathered plans.

(4) With respect to nongrandfathered plans of a policy under subdivision (2) of this subsection:

(A) The premium rates charged or offered shall be established on the basis of a single pool of all nongrandfathered plans, adjusted to reflect one or more of the following classifications:

(i) Age, in accordance with a uniform age rating curve established by the commissioner;

(ii) Geographic area, as defined by the commissioner;

(iii) Tobacco use, except that such rate may not vary by a ratio of greater than 1.5 to 1.0 and may only be applied with respect to individuals who may legally use tobacco under state and federal law. For purposes of this subparagraph, "tobacco use" means the use of tobacco products four or more times per week on average within a period not longer than the six months immediately preceding. "Tobacco use" does not include the religious or ceremonial use of tobacco;

(B) Total premium rates for family coverage shall be determined by adding the premiums for each individual family member, except that with respect to family members under twenty-one years of age, the premiums for only the three oldest covered children shall be taken into account in determining the total premium rate for such family.

(5) Premium rates for a grandfathered or nongrandfathered policy under subdivision (2) of this subsection may vary by (A) actuarially

justified differences in plan design, and (B) actuarially justified amounts to reflect the policy's provider network and administrative expense differences that can be reasonably allocated to such policy.

Sec. 4. Subsection (a) of section 38a-183 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(a) (1) A health care center governed by sections 38a-175 to 38a-192, inclusive, shall not enter into any agreement with subscribers unless and until it has filed with the commissioner a full schedule of the amounts to be paid by the subscribers and has obtained the commissioner's approval thereof. Such filing shall include an actuarial memorandum that includes, but is not limited to, pricing assumptions and claims experience, and premium rates and loss ratios from the inception of the contract or policy. The commissioner may refuse such approval if the commissioner finds such amounts to be excessive, inadequate or discriminatory. As used in this subsection, "loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations.

(2) Premium rates and special enrollment periods offered to individuals shall be consistent with the requirements set forth in section 38a-481, as amended by this act.

(3) Premium rates and special enrollment periods offered to small employers, as defined in section 38a-564, shall be consistent with the requirements set forth in section 38a-567, as amended by this act.

(4) No such health care center shall enter into any agreement with subscribers unless and until it has filed with the commissioner a copy of such agreement or agreements, including all riders and endorsements thereon, and until the commissioner's approval thereof has been obtained. The commissioner shall, within a reasonable time after the filing of any request for an approval of the amounts to be paid, any agreement or any form, notify the health care center of the

commissioner's approval or disapproval thereof.

Sec. 5. Section 38a-208 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(a) No such corporation shall enter into any contract with subscribers unless and until it has filed with the Insurance Commissioner a full schedule of the rates to be paid by the subscribers and has obtained said commissioner's approval thereof. Such filing shall include an actuarial memorandum that includes, but is not limited to, pricing assumptions and claims experience, and premium rates and loss ratios from the inception of the contract. The commissioner may refuse such approval if the commissioner finds such rates to be excessive, inadequate or discriminatory. As used in this subsection, "loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations.

(b) Premium rates and special enrollment periods offered to individuals shall be consistent with the requirements set forth in section 38a-481, as amended by this act.

(c) Premium rates and special enrollment periods offered to small employers, as defined in section 38a-564, shall be consistent with the requirements set forth in section 38a-567, as amended by this act.

(d) No hospital service corporation shall enter into any contract with subscribers unless and until it has filed with the Insurance Commissioner a copy of such contract, including all riders and endorsements thereof, and until said commissioner's approval thereof has been obtained. The Insurance Commissioner shall, within a reasonable time after the filing of any such form, notify such corporation of the commissioner's approval or disapproval thereof.

Sec. 6. Section 38a-218 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective*

January 1, 2017):

(a) No such medical service corporation shall enter into any contract with subscribers unless and until it has filed with the Insurance Commissioner a full schedule of the rates to be paid by the subscriber and has obtained said commissioner's approval thereof. Such filing shall include an actuarial memorandum that includes, but is not limited to, pricing assumptions and claims experience, and premium rates and loss ratios from the inception of the contract. The commissioner may refuse such approval if the commissioner finds such rates are excessive, inadequate or discriminatory. As used in this subsection, "loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations.

(b) Premium rates and special enrollment periods offered to individuals shall be consistent with the requirements set forth in section 38a-481, as amended by this act.

(c) Premium rates and special enrollment periods offered to small employers, as defined in section 38a-564, shall be consistent with the requirements set forth in section 38a-567, as amended by this act.

(d) No such medical service corporation shall enter into any contract with subscribers unless and until it has filed with the Insurance Commissioner a copy of such contract, including all riders and endorsements thereof, and until said commissioner's approval thereof has been obtained. The Insurance Commissioner shall, within a reasonable time after the filing of any such form, notify such corporation of the commissioner's approval or disapproval thereof.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2016*	38a-472f
Sec. 2	*January 1, 2017*	38a-567
Sec. 3	*January 1, 2017*	38a-481(g)

Sec. 4	*January 1, 2017*	38a-183(a)
Sec. 5	*January 1, 2017*	38a-208
Sec. 6	*January 1, 2017*	38a-218

INS *Unfavorable Pursuant to Joint Rule 19*